US Decisions Inc.

An Independent Review Organization
8760 A Research Blvd #512
Austin, TX 78758
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/23/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right ESI L4/L5 injection, anesthetic agent and/or steroid, transforaminal epidural with imaging guidance (fluoroscopy or CT)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Neurological Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for right ESI L4/L5 injection, anesthetic agent and/or steroid, transforaminal epidural with imaging guidance (fluoroscopy or CT) is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient reports that a fellow employee was having a seizure and the patient was trying to keep the individual from falling out of her chair. She was kicked in the abdomen resulting in injury to the abdomen and her lower back. The patient underwent a course of physical therapy in 2013. Lumbar MRI dated 09/17/13 revealed minimal bulging disc with narrowing of both neural foraminal at L4-5. Electrodiagnostic interpretation dated 07/14/14 is an unremarkable study. Office visit note dated 01/27/15 indicates that the patient complains of lumbar pain. The patient continues with low back pain radiating to the right leg with numbness and tingling with weakness. The patient underwent physical therapy in 8/13 with 30% improvement. Deep tendon reflexes are 2+ in the bilateral lower extremities. Strength is rated as 5/5 throughout. Straight leg raising is noted to be positive on the right and negative on the left. Sensory examination is grossly intact to fine touch and pinprick.

Initial request for right ESI L4-5 injection, anesthetic agent and or steroid, transforaminal epidural with imaging guidance-fluoroscopy or CT was non-certified on 01/30/15 noting that current evidence based guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. There is no current, detailed physical examination submitted for review to establish the presence of active radiculopathy, the patient's MRI fails to document any significant neurocompressive pathology and the submitted electrodiagnostic study is unremarkable. There is no indication that the patient has received any recent active treatment.

The denial was upheld on appeal dated 02/05/15 noting that the MRI showed no overt radicular finding nor did the EMG. There is no support for an epidural steroid injection based on either of these test results as per ODG requirements. There is also no indication why the MD is now requesting an L4-5 injection when he requested an L5-S1 injection in the past and the exam contains no specific findings relative to either an L4-5 or L5-S1 dermatomal involvement.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xx/xx/xx. The submitted records fail to indicate that the patient has undergone any active treatment since 2013. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The submitted EMG/NCV is an unremarkable study. The patient's physical examination documents 5/5 strength, 2+ deep tendon reflexes bilaterally and grossly intact sensation. As such, it is the opinion of the reviewer that the request for right ESI L4/L5 injection, anesthetic agent and/or steroid, transforaminal epidural with imaging guidance (fluoroscopy or CT) is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)